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STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC HEALTH SERVICES

NH PRESCRIPTION DRUG MONITORING PROGRAM  
29 HAZEN DRIVE, CONCORD, NH 0330  
Tel: 603-271-6978 Fax: 603-696-3150  
Email: NHPDMP@dhhs.nh.gov

REQUEST FOR WAIVER OF REPORTING REQUIREMENTS FOR  
NEW HAMPSHIRE PRESCRIPTION DRUG MONITORING PROGRAM

Please Provide the Information Requested Below. (Print or Type) Use Full Names not Initials

Name of Pharmacy/Veterinarian Facility		NH Pharmacy License Number (Not applicable for Veterinarians)	
Street Address		Email Address	
City, State		Zip Code	Area Code – Telephone Number
Pharmacy/Veterinarian DEA #	Name of Owner/Manager		Area Code – Telephone Number
Name of Pharmacist in Charge (PIC)/Vet	Pharmacist in Charge/Vet License #		Area Code – Telephone Number

If your pharmacy fall under a legislative exemption (RSA 318- B:31, IV): Check all that apply

- ☐ A wholesale distributor of a schedule II-IV controlled substance or it's analog.
- ☐ A licensed hospital pharmacy that dispenses for administration in the hospital.
- ☐ A licensed hospital pharmacy that dispenses less than a 48-hour supply of a schedule II-IV controlled substance from a hospital emergency department.
- ☐ A veterinarian who dispenses less than a 48-hour supply of a schedule II-IV controlled substance to a patient.

If the pharmacy is requesting a waiver from reporting: (Check one box below if applicable)

- ☐ \*The pharmacy does not have adequate computer systems and/or access to the Internet to electronically report Schedule II, III, or IV controlled substances to the NH PDMP. The pharmacy is responsible for reporting all required information by paper form or other media in accordance with the established time frame.
- ☐ \*The pharmacy does not currently deliver and/or dispense any drugs covered by the PDMP (Schedules II, III and/or IV controlled substances) to ultimate users with a New Hampshire address.
- ☐ Currently have an approved waiver and is renewing annually.

**\*Three months' worth of PDMP zero reports must accompany the waiver form for the above two waiver requests. You must zero report until your waiver is approved, PDMP data submitted needs to precede the date by three months of the date on the waiver. Waivers will not be accepted if documentation is not attached.**

By signing below I certify under penalty of perjury that all statements contained in this waiver application and any accompanying documents is true and correct:

If our business practices changes regarding dispensing drugs covered by the program, I will notify the PDMP and begin electronic data submission within one week as required.

My pharmacy will resubmit this form annually (January 1<sup>st</sup>) in order to re-certify that my pharmacy's status of delivering and/or dispensing of controlled substances have not changed.

Signature:	Date:
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For Department Use Only

Date Received:	<input type="checkbox"/> Approved <input type="checkbox"/> Modified Approval <input type="checkbox"/> Denied	Director or Designee Signature	Date of Action:
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Comment/Note: